Department for Mental Health and Mental Retardation Services
Facility Transition Practice

POLICY: The Cabinet for Health and Family Services and the Department for Mental Health and Mental Retardation Services through each of the state owned ICF/MR/DD centers will provide training, support and opportunities for individuals with mental retardation and developmental disabilities to remain in or return to living in the community.

PROCEDURE: Each ICF/MR/DD Center shall develop and implement a policy that will address all requirements identified in the ICF/MR/DD Strategic Action plan, including the ongoing role and functions of the center. The policy will ensure that treatment planning will include training and building of skills to enable individual's to remain in or return to a community home, the provision of education of the individual/family/guardian regarding community support options and other educational opportunities regarding community supports, appropriate transition planning and development of collaborative relationships with community providers and provider organizations.

A. ADMISSIONS:

Beginning upon admission to the center until discharged; each individual will be assessed for community placement, and each individual and family/guardian will be educated about community placement options during monthly, quarterly and annual Individual Life Plan reviews (ILP's),

1. Upon admission, a community transition profile will be completed
2. The admission team shall complete an initial assessment to identify specific barriers that may exist for continued community placement. The assessment will be presented to the interdisciplinary team assigned to the individual, within thirty (30) days, to assist in the treatment plan development.
3. In addition, the admission team shall:
    a) Evaluate the eligibility and needed supports of each individual applying for admission,
    b) Identify and record preliminary barriers that may create a challenge for the individual to remain in a community residential setting,
    c) Establish preliminary goals and timeframes for community placement,
    d) Educate the family/guardian of the purpose of the facility admission and the process to transition the individual back to a community setting.
2. Ongoing assessments and planning shall be completed through the interdisciplinary team (IDT) responsible for coordinating the treatment and planning.
3. The family/guardian of all individuals shall be provided the opportunity to be a participant of the interdisciplinary team.
4. The transition facilitator shall be responsible for all communication with the family/guardian related to the community transition process.

Note: a) Written approval for admission shall be obtained from the Secretary of the Cabinet for Health and Family Services (CHFS), when the admission is a transfer from another ICF/MR Facility.

b) Written approval for all admissions shall be obtained from the Commissioner of the Department for Mental Health/Mental Retardation and the Director of the Division of Mental Retardation.

B. EDUCATION:

1. Education shall be a function of the interdisciplinary team and shall include:
    a) The opportunity for the individual/family/guardian to be actively involved and provide input into the treatment planning process,
    b) Treatment strategies and expected outcomes,
    c) Education about alternative living options within the community,
    d) Opportunities to participate in community activities,
    e) Opportunities to visit community provider sites,
    f) Available choices for supports,
    g) Location and availability of services of providers.
2. Education and training of the community provider staff shall be provided in a coordinated effort by the center staff. The training shall be individualized to the Individual and identified through the assessment process.

C. Assessment:

1) The team shall meet on a monthly basis to review the current treatment plan. As part of the review, the team will consider the individuals readiness for community placement and address five (5) key areas:
    a) Compare current medical needs to those which can be provided in the community and identify any barriers for planning purposes and recommendations.
    b) Current medical needs to identify shall include: Medical stability, Medical and adaptive equipment and Medications.
    c) Assess current strategies regarding behavioral challenges and identify any barriers for planning purposes and recommendations.
    d) Behavioral assessments shall include:
        1. The success of strategies currently implemented, the cause(s) of the behavioral challenge, cycles of the behavioral challenges, current stability.
    e) Review the status of adult daily living skills. The review shall include:
        1. The identification of the necessary skills that would prepare the individual for community living developing strategies to teach the appropriate skills and set target dates for implementation and review.
        2. Assessment of the individuals' ability to be comfortable in various social settings and develop strategies to assist the individual in social settings that include home, community and work.
        3. Assessment of the success of current day services and develop strategies to assist the individual in adjusting toward a less restrictive environment based on the individual's interest.
2) Based on the discussion, the team shall arrive at a consensus regarding the individual's readiness to transition and document the recommendation in the resident record.
3) A recommendation, by the interdisciplinary team, that the individual is not ready for community placement shall be documented in the resident record and include:
    a) The barriers that exist,
    b) The strategies that have been developed to overcome barriers,
    c) Expected outcomes and timeframes,
    d) The next scheduled review.

D. Application for Alternative Living Options

The transition facilitator shall assist the individual and family/guardian in applying for community services. The individual shall sign the application(s) or when the individual is represented by a court appointed guardian, the guardian shall sign the application(s). Transition facilitators will submit the transition profile and application(s) to DMR and continue to track the progress and timelines of the individual's transition from the center..

E. Transition

Transition will be completed in a planned and systematic manner that ensure the safety and security of the individuals in addition to providing them with an array of appropriate, individualized and meaningful services. The Statewide Transition Process (Appendix A) shall be followed for all transitions.

1) The transition facilitator shall provide direct coordination of the specific transition process for the individual.
2) The transition facilitator shall be the central contact person from the center and shall monitor all transition activities.
3) The IDT shall write the person-centered plan that provides all information necessary for transitioning and shall review the information monthly.
4) The transition facilitator shall write the Transition Plan (Appendix C) that provides all the information necessary for the transition.
5) The individual and their family/guardian shall review a list of community providers to make a selection of the provider, services and area where the individual would like to live.
6) The selection shall be directed by the individual and their family/guardian and not be influenced by center staff.
7) The transition facilitator shall be available to guide the selection process.
8) The role of the transition facilitator shall include assisting in identifying barriers to community placement and appropriate strategies to address these barriers as well as identification as to the type of supports needed for transitioning into the community.
9) Upon completion of the provider selection and acceptance by the community provider, the transition facilitator shall schedule a planning meeting to identify the supports necessary for the individual in the community, number and type of provider visits to be scheduled, identify the specific staff cross training to be provided and to review the ILP for appropriate training objectives and develop the Transition Plan.
10) Participants in the planning meeting shall include the facilitator, the interdisciplinary team, the community provider staff and the DMR area administrator for the selected provider. Additionally, the individual and their family/guardian may identify persons they wish to be present in the meeting such as friends or an advocate.
11) The transition facilitator shall be responsible for ensuring that all identified planning team representatives are invited to the meeting.
12) Upon completion of the planning meeting(s), the transition facilitator shall prepare the transition plan, with input from the team members, for submission to the Director of Transition Services.
13) The Director of Transition Services shall ensure all sections of the plan have been addressed and provide feedback to the transition facilitator who shall make any revisions to the final plan and return to the Director of Transition Services.

14) The transition facilitator shall schedule additional transition planning meetings as needed and a final discharge meeting.

15) The case manager shall be responsible for a discharge meeting to ensure:
    a. All issues have been addressed and a completion date is established for any outstanding issues,
    b. Training requirements have been identified and completed,
    c. Visits have occurred and feedback is received and utilized for any revisions to the transition plan,
    d. Adaptive equipment needs have been identified and purchase has been authorized,
    e. The final transition plan and community crisis plan have been distributed, and
    f. The transition date has been confirmed.

16) The transition plan shall include the transition profile, the Individual Life Plan, the Facility Medication Administration Record, the Community Crisis Plan, the transition checklist, the community placement visit survey, and the preparing for the move and day of the move checklists.

17) When an individual transitions from the center the individual's current funds and income must transition with them.
    a. Transition of funds shall include notification of the centers Financial Services of the following:
        i. the need to complete a MAP 24 form to the local office of Department for Community Based Services, and
        ii. the name and address of the new provider.
    b. The new provider will go to their local community and complete a MAP 24,
    c. The Rep-payee will need to be changed for individuals with Social Security if the center is designated as the Rep-payee at the time of discharge. The new provider/person that will be the new Re-payee will go to their local Social Security Office and apply to be Rep-payee.
        i. The Social Security Administration will notify the center's Financial Services, once the Re-payee is approved.

F. <u>Community Placement and Follow Up</u>

1.) The transition facilitator shall be responsible for confirming the completion of all outstanding issues from the transition discharge meeting.

2.) On the date of transition to community placement, center staff shall:
    a) Complete the transition checklist and confirm items are packed for the transition. Obtain confirmation from the community residential staff that all items have arrived through signature by the community staff person.
    b) The transfer of supports shall be implemented at the individual's new home in the community.
    c) Center staff shall remain at the home long enough to ensure that the individual has settled into their new home.

3.) Center staff shall be aware of the individual's specific needs and shall determine the length of time necessary for the adjustment.

4.) In an effort to provide an opportunity for a successful transition to community life, the transition shall not be considered complete until after three hundred sixty-five (365) days.

5.) Follow up activities shall include:
    a) Telephone contact by the transition facilitator to the individual's case manager the day after the transition. The call shall be documented in a progress note regarding the

process and how the individual is adjusting.

b) Center staff, in conjunction with DMR staff, shall complete pre-arranged follow up visits to discuss the individual's adjustment and to provide consultation regarding issues that may have been identified since the transition. These visits shall occur at least every thirty (30) days during the first ninety (90) day period, and will be completed at six (6) and twelve (12) months, to ensure continuity of care.

c) Center staff shall document the follow up visit(s) by all participants and submit to the Director of Transition Services for tracking and follow up. Copies shall be forwarded to DMR. (Post Transition Checklist attached)